

CAN-DO

Christian Access to
NeuroDevelopmental Organization

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CLIENT HISTORY AND PROGRAM APPLICATION

Today's Date _____
Form is completed by Self _____ Spouse _____ Parent _____ Guardian _____ (please check one)
Client's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
Country _____ Email Address _____
Mailing Address (if different than above) _____

Client lives with: Self _____ Spouse _____ Parent _____ Guardian _____ Other _____ (please check one)
Is the client adopted? Yes _____ No _____

Father's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
Country _____ Email Address _____
Occupation _____ Education Completed _____

Mother's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
Country _____ Email Address _____
Occupation _____ Education Completed _____

Guardian's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
Country _____ Email Address _____
Occupation _____ Education Completed _____

Client's Name _____ Date _____

Siblings:

Name _____	Age _____
Name _____	Age _____
Name _____	Age _____
Name _____	Age _____
Name _____	Age _____
Name _____	Age _____
Name _____	Age _____
Name _____	Age _____

MEDICAL HISTORY

Family Physician _____ Telephone _____

Address _____

Client's birth weight ____ lbs ____ oz Apgar Scores (if known) 1. ____ 2. ____

Length of pregnancy _____ Complications during pregnancy and/or delivery? Yes/no

Please Describe:

Age of client when parent first had any concerns about development _____

pertinent medical, neurological, visual, hearing, therapeutic, psychological or educational testing:

Date	Examined By	Diagnosis	Recommendations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries? Yes/No

Please describe _____

Broken limbs? Yes/no

List specifics _____

Are there any medical problems, which place limitations on physical activity, etc.?

yes/no

List _____

Client's Name _____ Date _____

Seizures? Yes/no
Frequency of Seizures _____ Length _____

Type(s) _____

Currently taking seizure medications? Yes/No

List medication(s) _____

Seizure medications taken previously? Yes/no

List medication(s) _____

Other medications? Yes/No

List medication(s) _____

Describe the client's diet _____

	Excessive	Daily	Weekly	Rarely	Never
Vegetable	___	___	___	___	___
Fruits	___	___	___	___	___
Meats	___	___	___	___	___
Sugar	___	___	___	___	___
Artificial colorings	___	___	___	___	___
Dairy products	___	___	___	___	___
White flour	___	___	___	___	___
Tobacco	___	___	___	___	___
Alcohol	___	___	___	___	___

List dietary supplements and vitamins

Food allergies? Yes/no/never tested

Food cravings? Yes/no Picky eater? Yes/no Overeats? Yes/no Poor appetite? Yes/no

Client's Name _____ Date _____

Allergies? Yes/no
Please describe _____

Does the client have a history of colds or sinus congestion? Yes/no

Does the client have a history of ear infections? Yes/no

Which ears have been affected? _Left _Right _Both

Does the client have a hearing loss? Yes/no

Does the client have hypersensitive hearing? Yes/no

Has the client had a tympanogram? Yes/no
What were the results _____

Has the client had an eye examination? Yes/no

Does the client wear glasses or contact lenses? Yes/no
Prescription _____

Has the client ever received vision therapy? Yes/no
Please describe _____

Has the client been diagnosed with any of the following: (Please check)
 Near sighted far sighted astigmatism amblyopia
 Strabismus macular problems glaucoma cataracts
 Nystagmus blind cortical blindness other

Sleep times from _____ to _____ Naps from _____ to _____

Client physical activity level
Daily? Yes/no How many days per week _____
Types of activities _____
Duration of activities _____

Is the client seeing a specialist? Yes/no (please check)
 Neurologist Counselor Other _____
 Psychologist/Psychiatrist Chiropractor _____
 Nutritionist Speech therapist _____
 Physical therapist Occupational therapist _____
 Vision therapist Orthopedist _____
 Cardiologist Tutor _____

Other health problems? Yes/no
List _____

Client Name _____ Date _____

BEHAVIOR

Does the client have a history of emotional or behavioral disorders? Yes/no
Please describe _____

Is there a family history of emotional or behavioral disorders? Yes/no
Please describe _____

Client's specific positive behaviors _____

Client's specific negative behaviors _____

Do you have specific behavioral goals for the client? Yes/no
Please describe _____

Distractibility	yes/no/not sure	likes competitive games	yes/no/not sure
Short attention span	yes/no/not sure	avoidance behavior	yes/no/not sure
Hyperactive	yes/no/not sure	difficulty following directions	yes/no/not sure
Hypoactive (low activity level)	yes/no/not sure	difficulty with parents	yes/no/not sure
Rigid or inflexible	yes/no/not sure	difficulty with siblings	yes/no/not sure
Impulsive	yes/no/not sure	difficulty with teachers	yes/no/not sure
Temper tantrums	yes/no/not sure	difficulty with peers	yes/no/not sure
Sucks thumb	yes/no/not sure	overly sensitive to sound	yes/no/not sure
Few or no friends	yes/no/not sure	overly sensitive to touch	yes/no/not sure
Socially immature	yes/no/not sure	overly sensitive to odors	yes/no/not sure
Perseverating		tics	yes/no/not sure
(Talking on a topic)	yes/no/not sure	phobias	yes/no/not sure
Low frustration level	yes/no/not sure	emotional	yes/no/not sure
Overreacts	yes/no/not sure	overly sensitive	yes/no/not sure
Destructive behavior	yes/no/not sure	high tolerance for pain	yes/no/not sure
Aggressive behavior	yes/no/not sure	low tolerance for pain	yes/no/not sure
Cyclical behavior		compliant	yes/no/not sure
(Good days/bad days)	yes/no/not sure	cooperative	yes/no/not sure
Academic output		obedient	yes/no/not sure
(Good days/bad days)	yes/no/not sure	organized	yes/no/not sure

PHYSICAL MOTOR SKILLS (Please check problem areas)

Low muscle tone	_____	athotoid movement	_____
High muscle tone	_____	ataxic	_____
Coordination	_____	weak	_____
Crawling	_____	balance	_____
Walking	_____	other	_____
Running	_____		

Client Name _____ Date _____

HAND PREFERENCE

	Right	Mixed	Left
Writing	_____	_____	_____
Eating	_____	_____	_____
Throwing	_____	_____	_____
Brushing teeth combing hair	_____	_____	_____
Sports	_____	_____	_____
Other _____	_____	_____	_____

LANGUAGE AND READING SKILLS

Articulation problems	yes/no/not sure	mirror writing	yes/no/not sure
Stammer or stutter	yes/no/not sure	forgetful	yes/no/not sure
Aphasia	yes/no/not sure	right/left confusion	yes/no/not sure
Poor pencil grasp	yes/no/not sure poor	judge of time	yes/no/not sure
Sloppy writing	yes/no/not sure poor	reading ability	yes/no/not sure
Difficulty copying from Blackboard	yes/no/not sure	poorly organized letter reversals	yes/no/not sure

MATH RELATED

Problems with math:			
Computation	yes/no/not sure	word problems	yes/no/not sure
Concepts	yes/no/not sure	poor logic	yes/no/not sure

DEVELOPMENTAL HISTORY

Age	crawled (on stomach)	_____ years _____ months
	Crept (on hands and knees)	_____ years _____ months
	Walk	_____ years _____ months
	Toilet trained	_____ years _____ months
	First word	_____ years _____ months
	Use of couplets (two words together)	_____ years _____ months
	3-4 word phrases	_____ years _____ months
	Sentences	_____ years _____ months
	Conversational language	_____ years _____ months
	Read	_____ years _____ months

Client's Name _____ Date _____

Does the client enjoy watching television?	Yes/no
Does the client enjoy being read to?	Yes/no
Does the client enjoy reading books?	Yes/no
Speech and language problems?	Yes/no
Fine motor problems?	Yes/no
Gross motor problems?	Yes/no
Does the client bed wet?	Yes/no

EDUCATIONAL HISTORY

List all schools attended, years attended, grade completed or degrees earned.

List any educational problems.

List any labels, classifications, or educational diagnoses.

List any exceptional abilities, academic, physical, artistic, musical....

Lessons (musical, physical/sports, art, language, etc.

Are there any events, which may be currently affecting the client adversely? Yes/no

Please describe _____

Client's Name _____

Date _____

GOALS AND PLAN

What are your goals and expectations?

Who will implement the program? _____

Daily Length of time parents can work with client _____

Daily Length of time other's can work with client _____

How did you hear about CAN-DO? _____ When did you first hear? _____

Christian Access to NeuroDevelopmental Organization is an organization of parents and professionals dedicated to assisting individuals in the achievement of their innate God given potentials. CAN-DO is continually investigating, researching and utilizing the best methods available in this endeavor. Program recommendations are not medical, therapeutic, or psychological prescriptions. Program recommendations are offered for the client and family's review investigation and education. Application of said procedures is the responsibility of the client and family. Cyndi Ringoen, (founder of CAN-DO), is a mother and developmentalist. She does not, nor is she licensed, to practice medicine. If medical or other licensed professional advice is needed the family is urged to consult a licensed physician or other licensed professional.

I acknowledge that I have read and completed this information to the best of my knowledge and ability, and that I understand that neither CAN-DO nor those trained by or employed by Can-Do are assuming responsibility or liability for the client, and that I, as parent, guardian, or client, assume full responsibility.

Signature _____ Date _____ Signature _____ Date _____